

## **Senate Bill No. 1368**

### **CHAPTER 526**

An act to amend Sections 129040 and 129050 of the Health and Safety Code, and to amend Sections 12695.18 and 12705 of the Insurance Code, relating to health, and making an appropriation therefor.

[Approved by Governor September 29, 2010. Filed with  
Secretary of State September 29, 2010.]

#### **LEGISLATIVE COUNSEL'S DIGEST**

SB 1368, Committee on Health. Health care.

(1) Existing law establishes the Office of Statewide Health Planning and Development and sets forth its powers and duties, including, but not limited to, administration of the California Health Facility Construction Loan Insurance Law for the purposes of insuring health facility construction loans. Existing law establishes the Health Facility Construction Loan Insurance Fund and continuously appropriates the fund to the office for these purposes. Existing law authorizes the office to charge a premium charge for the insurance of these loans, with the premiums to be deposited in the fund.

This bill would authorize the office to annually charge a portion of the premium in advance not to exceed \$6 per year for each \$1,000 of principal of the proposed loan. The bill would make the total dollar amount of the premium advanced nonrefundable and would require that it be credited against the amount of the premium charged or, if the commitment expires and the loan is not insured, the bill would require that the advance be retained by the office to offset costs and expenses of the office, as prescribed. By increasing the amounts to be deposited into a continuously appropriated fund, this bill would make an appropriation.

Existing law sets forth the conditions for loans to be eligible for loan insurance under these provisions, including, but not limited to, the requirement that the proceeds of the loan be guaranteed to be used exclusively for the construction, improvement, or expansion of the health facility, as approved by the office.

Existing law also authorizes insurance of loans to refinance another prior loan if the prior loan would have been eligible at the time it was made.

This bill would, instead, permit the refinancing of up to 90% of a prior loan if the loan would otherwise be eligible, without regard to whether the prior loan would have been eligible at the time it was made. By expanding the purposes for which a continuously appropriated fund may be expended, this bill would make an appropriation.

(2) Existing law creates the Access for Infants and Mothers Program, which is administered by the Managed Risk Medical Insurance Board, to provide coverage for perinatal and infant care to residents of this state

meeting certain income and other eligibility requirements and paying certain subscriber contributions.

Existing law creates the California Major Risk Medical Insurance Program, which is also administered by the board, to provide major risk health coverage to residents of this state who are unable to secure adequate private health coverage because of preexisting medical conditions and who meet other eligibility requirements and pay certain subscriber contributions.

This bill would delete obsolete references within these provisions.

Appropriation: yes.

*The people of the State of California do enact as follows:*

SECTION 1. Section 129040 of the Health and Safety Code is amended to read:

129040. (a) The office shall establish a premium charge for the insurance of loans under this chapter, and this charge shall be deposited in the fund. A one-time nonrefundable premium charge shall be paid at the time the loan is insured. The premium rate may vary based upon the assessed level of relative financial risk determined pursuant to Section 129051, but shall in no event be greater than 3 percent. The amount of premium shall be computed on the basis of the application of the rate to the total amount of principal and interest payable over the term of the loan.

(b) The office may annually charge a portion of the premium in advance commencing at the time of issuing or extending the commitment until the date the loan is insured or the commitment expires. The amount of the advance premium shall not exceed six dollars (\$6) per year for each one thousand dollars (\$1,000) of principal of the proposed loan. The total dollar amount of the premium advanced shall be nonrefundable and shall be credited against the amount of the premium charged pursuant to this section, or if the commitment expires and the loan is not insured, the advance shall be retained by the office to offset costs and expenses of the office related to preliminary work, underwriting the loan commitment, and monitoring construction.

SEC. 2. Section 129050 of the Health and Safety Code is amended to read:

129050. A loan shall be eligible for insurance under this chapter if all of the following conditions are met:

(a) The loan shall be secured by a first mortgage, first deed of trust, or other first priority lien on a fee interest of the borrower or by a leasehold interest of the borrower having a term of at least 20 years, including options to renew for that duration, longer than the term of the insured loan. The security for the loan shall be subject only to those conditions, covenants and restrictions, easements, taxes, and assessments of record approved by the office, and other liens securing debt insured under this chapter. The office may require additional agreements in security of the loan.

(b) The borrower obtains an American Land Title Association title insurance policy with the office designated as beneficiary, with liability equal to the amount of the loan insured under this chapter, and with additional endorsements that the office may reasonably require.

(c) The proceeds of the loan shall be used exclusively for the construction, improvement, or expansion of the health facility, as approved by the office under Section 129020. However, loans insured pursuant to this chapter may include loans to refinance another prior loan, whether or not state insured and without regard to the date of the prior loan, if the office determines that the amount refinanced does not exceed 90 percent of the original total construction costs and is otherwise eligible for insurance under this chapter. The office may not insure a loan for a health facility that the office determines is not needed pursuant to subdivision (k).

(d) The loan shall have a maturity date not exceeding 30 years from the date of the beginning of amortization of the loan, except as authorized by subdivision (e), or 75 percent of the office's estimate of the economic life of the health facility, whichever is the lesser.

(e) The loan shall contain complete amortization provisions requiring periodic payments by the borrower not in excess of its reasonable ability to pay as determined by the office. The office shall permit a reasonable period of time during which the first payment to amortization may be waived on agreement by the lender and borrower. The office may, however, waive the amortization requirements of this subdivision and of subdivision (g) of this section when a term loan would be in the borrower's best interest.

(f) The loan shall bear interest on the amount of the principal obligation outstanding at any time at a rate, as negotiated by the borrower and lender, as the office finds necessary to meet the loan money market. As used in this chapter, "interest" does not include premium charges for insurance and service charges if any. Where a loan is evidenced by a bond issue of a political subdivision, the interest thereon may be at any rate the bonds may legally bear.

(g) The loan shall provide for the application of the borrower's periodic payments to amortization of the principal of the loan.

(h) The loan shall contain those terms and provisions with respect to insurance, repairs, alterations, payment of taxes and assessments, foreclosure proceedings, anticipation of maturity, additional and secondary liens, and other matters the office may in its discretion prescribe.

(i) The loan shall have a principal obligation not in excess of an amount equal to 90 percent of the total construction cost.

(j) The borrower shall offer reasonable assurance that the services of the health facility will be made available to all persons residing or employed in the area served by the facility.

(k) The office has determined that the facility is needed by the community to provide the specified services. In making this determination, the office shall do all of the following:

(1) Require the applicant to describe the community needs the facility will meet and provide data and information to substantiate the stated needs.

(2) Require the applicant, if appropriate, to demonstrate participation in the community needs assessment required by Section 127350.

(3) Survey appropriate local officials and organizations to measure perceived needs and verify the applicant's needs assessment.

(4) Use any additional available data relating to existing facilities in the community and their capacity.

(5) Contact other state and federal departments that provide funding for the programs proposed by the applicant to obtain those departments' perspectives regarding the need for the facility. Additionally, the office shall evaluate the potential effect of proposed health care reimbursement changes on the facility's financial feasibility.

(6) Consider the facility's consistency with the Cal-Mortgage state plan.

(l) In the case of acquisitions, a project loan shall be guaranteed only for transactions not in excess of the fair market value of the acquisition.

Fair market value shall be determined, for purposes of this subdivision, pursuant to the following procedure, that shall be utilized during the office's review of a loan guarantee application:

(1) Completion of a property appraisal by an appraisal firm qualified to make appraisals, as determined by the office, before closing a loan on the project.

(2) Evaluation of the appraisal in conjunction with the book value of the acquisition by the office. When acquisitions involve additional construction, the office shall evaluate the proposed construction to determine that the costs are reasonable for the type of construction proposed. In those cases where this procedure reveals that the cost of acquisition exceeds the current value of a facility, including improvements, then the acquisition cost shall be deemed in excess of fair market value.

(m) Notwithstanding subdivision (i), any loan in the amount of ten million dollars (\$10,000,000) or less may be insured up to 95 percent of the total construction cost.

In determining financial feasibility of projects of counties pursuant to this section, the office shall take into consideration any assistance for the project to be provided under Section 14085.5 of the Welfare and Institutions Code or from other sources. It is the intent of the Legislature that the office endeavor to assist counties in whatever ways are possible to arrange loans that will meet the requirements for insurance prescribed by this section.

(n) The project's level of financial risk meets the criteria in Section 129051.

SEC. 3. Section 12695.18 of the Insurance Code is amended to read:

12695.18. "Participating health plan" means any of the following plans that are lawfully engaged in providing, arranging, paying for, or reimbursing the cost of personal health care services under insurance policies or contracts, medical and hospital service arrangements, or membership contracts, in consideration of premiums or other periodic charges payable to it, and that contracts with the program to provide coverage to program subscribers:

(a) A private insurer holding a valid outstanding certificate of authority from the Insurance Commissioner.

(b) A nonprofit membership corporation lawfully operating under the Nonprofit Corporation Law (Division 2 (commencing with Section 5000) of the Corporations Code).

(c) A health care service plan as defined under subdivision (f) of Section 1345 of the Health and Safety Code.

(d) A county or a city and county, in which case no license or approval from the Department of Insurance or the Department of Managed Health Care shall be required to meet the requirements of this part.

(e) A comprehensive primary care licensed community clinic that is an organized outpatient freestanding health facility and is not part of a hospital that delivers comprehensive primary care services, in which case, no license or approval from the Department of Insurance or the Department of Managed Health Care shall be required to meet the requirements of this part.

SEC. 4. Section 12705 of the Insurance Code is amended to read:

12705. For the purposes of this part, the following terms have the following meanings:

(a) “Applicant” means an individual who applies for major risk medical coverage through the program.

(b) “Board” means the Managed Risk Medical Insurance Board.

(c) “Fund” means the Major Risk Medical Insurance Fund, from which the program may authorize expenditures to pay for medically necessary services which exceed subscribers’ contributions, and for administration of the program.

(d) “Major risk medical coverage” means the payment for medically necessary services provided by institutional and professional providers.

(e) “Participating health plan” means a private insurer (1) holding a valid outstanding certificate of authority from the Insurance Commissioner, a nonprofit membership corporation lawfully operating under the Nonprofit Corporation Law (Division 2 (commencing with Section 5000) of the Corporations Code), or a health care service plan as defined under subdivision (f) of Section 1345 of the Health and Safety Code, which is lawfully engaged in providing, arranging, paying for, or reimbursing the cost of personal health care services under insurance policies or contracts, medical and hospital service agreements, or membership contracts, in consideration of premiums or other periodic charges payable to it, and (2) which contracts with the program to administer major risk medical coverage to program subscribers.

(f) “Plan rates” means the total monthly amount charged by a participating health plan for a category of risk.

(g) “Program” means the California Major Risk Medical Insurance Program.

(h) “Subscriber” means an individual who is eligible for and receives major risk medical coverage through the program, and includes a member of a federally recognized California Indian tribe.

(i) “Subscriber contribution” means the portion of participating health plan rates paid by the subscriber, or paid on behalf of the subscriber by a federally recognized California Indian tribal government. If a federally

recognized California Indian tribal government makes a contribution on behalf of a member of the tribe, the tribal government shall ensure that the subscriber is made aware of all the health plan options available in the county where the member resides.

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